

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN6901	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2011
NAME OF PROVIDER OR SUPPLIER PICKETT CARE AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 129 HILLCREST DRIVE BYRDSTOWN, TN 38549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 831	<p>1200-8-6-.08(1) Building Standards</p> <p>(1) The nursing home must be constructed, arranged and maintained to ensure the safety of the resident.</p> <p>This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the nursing home to ensure the safety of the residents as required.</p> <p>The findings include:</p> <p>On 6/13/11 at 3:05 PM, observation within room 131 bathroom revealed the vinyl finished floor was damaged near the floor drain. This finding was corrected during the survey.</p> <p>This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/13/11.</p>	N 831	<p>N 831 Corrective Actions for residents affected:</p> <p>Floor was repaired by Maintenance Supervisor as stated on the 2567. The facility had already been in process of replacing the restroom floor coverings for this hall and this was the final room.</p> <p>Identification of residents with potential to be affected: On 6/14/11 the Maintenance Supervisor examined all other flooring for any need of repair with no other findings discovered.</p> <p>K 038 continued Measures to prevent reoccurrence: The Maintenance Supervisor conducts a monthly safety walkthrough that will include examination for restroom floors for need of repair. Repairs will be facilitated by the facility Maintenance Supervisor or by hired contractor as need arises.</p> <p>Monitoring of Corrective Action: As a means of Quality Assurance the Maintenance Supervisor will report findings to the monthly safety committee.</p>	6/13/11

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6890

NMVW21

TITLE

Administrator

(X6) DATE

6/28/11

If continuation sheet 1 of 1